GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR SETTLEMENT MEDIATION

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYER Name

Address | Phone Number

Employer E-mail

PARTY AT INTEREST OR SITF Name

Address | Phone Number

Party E-mail

ATTORNEY FOR EMPLOYEE/CLAIMANT Name

Address | Phone Number

Attorney Bar Number

Attorney E-mail

EMPLOYEE Phone Number | County of Injury

Address

Employee E-mail

INSURER / SELF-INSURER Name

CLAIMS OFFICE Name

Address | Phone Number

Claims E-mail

ATTORNEY FOR EMPLOYER / INSURER Name

Address | Phone Number

Attorney Bar Number

Attorney E-mail

B. SETTLEMENT REQUEST INFORMATION

MSA Involved?	Catastrophic Injury Designation?	SITF Accepted Claim?
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

C. CERTIFICATION

❑ By the filing of this Request for Settlement Mediation, all parties certify that they agree to participate in mediation for the purpose of settlement of the above referenced claim(s). The parties hereby further certify that the employer/insurer or self-insurer has obtained, or will obtain by the date of the first setting of this matter, settlement authority based upon a good faith evaluation of this claim, and that all parties are otherwise prepared to go forward. If this claim involves a request for reimbursement from the Subsequent Injury Trust Fund, the parties hereby certify that the Fund has been made aware of the settlement conference or agrees to a settlement conference and has been provided with all necessary documentation.

D. ENTRY OF APPEARANCE

❑ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or Form WC 102B filed in compliance of Board Rule 102. (A fee contract or Form WC 102B has been filed previously or is attached).

E. CERTIFICATE OF SERVICE

❑ I hereby certify that I have today sent a copy of this form to all of the parties named above and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Signature of Employee Representative	Date	Signature of Employer/Insurer Representative	Date

Print Name and Telephone Number Here	Print Name and Telephone Number Here
E-mail	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).